Ithaca Orthopaedic Group, PC

♦ 10 Brentwood Dr., Suite B ♦ Ithaca, NY 14850 ♦ (607) 266-0073 ♦ Fax (607) 266-9310 ♦

Medical Form

Name: ____ Date: ______________ Age:_______ DOB:_______________

Height: ________________________ Weight: ________________ Male: ________ Female: __________

Nature of onset of this problem:
Gradually _____________ Suddenly ___________ Re-Injury___________________________________

Where: Home __________Work __________ Auto __________ Liability___________Other_________

What body part are you being seen for today:____
Right, Left, or Bi-lateral (please circle one)

How did the injury/problem occur: ____

____

Date of Injury/Onset: ____

Have you ever had this condition before? Yes _________ No __________and if **YES** when, where and treated by

whom?____

Have you had previous X-ray/MRI for your condition? Yes _________ No __________

If **YES**, When and Where?____

Work Status: Are you off work due to your present orthopedic problem? Yes _______ No______

If **YES**, who took you out of work and on what date? ___________________________________

Is the pain **Mild, Moderate or Severe**? (Circle one)

Your **Major** complaint: (check all that apply)

____ aching pain ____ burning pain ____ stabbing pain ____ pain at night
____ deformity ____ loss of motion ____ loss of strength ____ swelling
____ giving out ____ locking ____ grinding ____ numbness or tingling
____ other____

Medications you are taking: (Including all prescription drugs, over the counter, aspirin, Advil, herbs and supplements)____

____

____

Are you allergic to any medications? Yes______ No _______If **YES,** please list them_______________________________________

____

Please list all surgeries you have had: ____

____

Have you ever been hospitalized other than for the above? YES______ NO______
If **YES,** please explan?____

Review of Systems: Please check all that you CURRENTLY have:

Gastro
__weight change
__fever or chills
__night sweats
__frequent urination
__lumps or masses
__dizziness or fainting

General
__visual change
__hearing change
__ringing in ears
__dentures
__bleeding gums
__hoarseness or sore throat

ENT
__difficulty swallowing
__nausea & vomiting
__Jaundice
__blood in stool
__diarrhea or colitis

Genitourinary
__loss of control urine / stool
__menopause
__burning with urination
__difficulty urinating

Breast
__lumps, pain, discharge

Heart
__chest pain or angina
__swelling of ankles

Respiratory
__cough or sputum
__shortness of breath

Musculoskeletal
__backache
__joint pain / swelling

Neurologic
__numbness
__weakness

Have you ever had or do you now have any of the following:

Cardiovascular Disease Yes ____ No _____

Kidney Disease Yes ____ No_____

HIV Positive Yes ____ No_____

Stomach/Peptic/Ulcer Yes ____ No_____

Thyroid Disease Yes ____ No_____

High Blood Pressure Yes ____ No_____

Diabetes Yes ____ No_____

Bleeding Disorder Yes ____ No_____

Stroke Yes ____ No____

Heart Attack Yes ____ No____

Tuberculosis Yes ____ No____

Hepatitis Yes ____ No____

Asthma Yes ____ No____

Rheumatic Fever Yes ____ No____

Polio Yes ____ No____

Please list any other conditions which you have or have had in the past but have not been noted above. Include any history of fractures, dislocations and other orthopedic problems: ____

____

==

Do you have a Family History of:

(If yes, please indicate WHOM by **F** for father, **M** for mother, **GM** for Grandmother or **GF** for Grandfather)

Diabetes Yes____ No_____ WHOM _____

Anesthesia Problems Yes____ No_____ WHOM_____

Arthritis Yes_____ No____ WHOM_____

Heart Attack Yes____ No_____ WHOM _____

Stroke Yes____ No_____ WHOM_____

Cancer Yes_____ No_____ WHOM _____ What Kind: ________________________________

Other: ______________________________ WHOM_____

==

I am Right handed ______Left handed ______ Truly ambidextrous _____

What are your hobbies/interests?____

Have you ever smoked? Yes ____ No ____ Quit _____ (if Yes) When, how much and for how long?

____

Do you drink alcohol? Yes ____ No ____ If yes, how much in a typical day?

____

Female Patients Only:

Is there any possibility that you are pregnant? Yes ____ No _____ If yes, date of your last Menstrual cycle: ____________________

To my knowledge, this information is correct and complete:

Patient Signature: ____

Legal Guardian Signature, if patient is a minor:_______________________________________